1.10 Eligibility

Anyone receiving covered services should have a Medicaid identification card at the time of service. If the beneficiary cannot present an ID card at the time of service, eligibility can be determined through use of either of the following services:

- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/ Beneficiary Services Call Center at 1-800-884-3222
- Envision web portal at https:/ / msmedicaid.acs-inc.com
- MEVS transaction using personal computer (PC) software or point of service (POS) swipe card verification device provided by switch vendors.

Eligibility should be verified each time a service is provided whether or not the beneficiary is able to present an ID card.

Medicaid Eligibility Verification Services

Medicaid Eligibility Verification Services (MEVS) transactions may be submitted using PC software or POS devices provided by MEVS switch vendors. When using a POS device the Medicaid card can be swiped through the terminal's card reader slot, or the beneficiary's access information can be entered by hand. This option is not available when using PC software or automated voice response. Various switch vendors offer differing methods for gaining access to the eligibility system. They communicate with the Envision claims processing system to obtain detailed beneficiary eligibility and coverage information. MEVS information is available 24 hours a day, seven days per week. There is a charge for each transaction and rates depend on the MEVS switch vendor selected. Vendors authorized for MEVS services are shown below.

VENDOR	CONTACT INFORMATION
Envoy Corporation	**1-800-366-5716**
Healthcare Data Exchange Corporation	**1-610-219-1784**
Medifax/The Potomac Group Inc.	**1-800-444-4336**
National Data Corporation	**1-800-218-1500**

Mississippi Medicaid Benefits and Categories of Eligibility (COE)

Whether verifying eligibility of beneficiaries through the web portal, the AVRS, the call center or through a MEVS transaction, the chart listed below is for assistance in determining what benefits and exclusions apply to the category of eligibility for which the beneficiary is deemed eligible for Medicaid services.

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS
001	SSI Individual via SDX	Full Medicaid Benefits	
002	SSI Retro Eligibility	Full Medicaid Benefits	
003	IV-E Foster Care/ Adoption Assistance Related	Full Medicaid Benefits	
005	SSI in Institution	Full Medicaid Benefits	
006	Protected SSI Child	Full Medicaid Benefits	
007	Protected Foster Care Child	Full Medicaid Benefits	
010	Nursing Home, under 300% FPL	Full Medicaid Benefits	
011	Long Term Hospital, under 300%	Full Medicaid Benefits	
012	Swing Bed, under 300% FPL	Full Medicaid Benefits	
013	NH, Eligible at Home	Full Medicaid Benefits	
014	Long Term Hospital, SSI Eligible at Home	Full Medicaid Benefits	
015	Swing Bed, SSI Eligible at Home	Full Medicaid Benefits	
019	Disabled Child at Home	Full Medicaid Benefits	
020	Emergency SSI Limitations Case	Full Medicaid Benefits	
021	Emergency Immigrant	Medicaid Benefits for Date of Service Only	All dates other than Date of Service
025	Working Disabled	Full Medicaid Benefits	
026	CWS Foster Care/ Adoption Assistance Child	Full Medicaid Benefits	
029	Family Planning	Limited Medicaid; Family Planning Benefits Only	All other benefits
031	Qualified Medicare Beneficiary (QMB)	Medicaid payment of Medicare Parts A and B • Premiums • Deductibles • Coinsurance	All other benefits
035	Qualified Working Disabled Individual (QWDI)	Medicaid payment of Medicare Parts A • Premium	Non-covered Medicare Services non-emergency transportation
045	Healthier MS Waiver Only (No Medicare)	Limited Medicaid Benefits - includes NET service	Long term care, hospice, dental, eyeglasses, podiatry, chiropractic, therapy at free-standing clinic

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS
051	Specified Low-Income Medicare (SLMB)	Medicaid payment of Medicare Part B Premium	All other Medicaid Benefits
054	Qualified Individual (QI-1)	Medicaid payment of Medicare Part B Premium	All other Medicaid Benefits
062	HCBS Assisted Living Waiver	Full Medicaid Benefits	
063	HCBS Elderly/ Disabled Waiver	Full Medicaid Benefits	
064	HCBS ID/ DD Waiver	Full Medicaid Benefits	
065	HCBS Independent Living Waiver	Full Medicaid Benefits	
066	TBI/ SCI Waiver (Traumatic Brain Injury/ Spinal Cord Injury)	Full Medicaid Benefits	
067	SED Waiver/ MYPAC	Full Medicaid Benefits	Mental Health benefits are only available through a MYPAC provider.
085	Medical Assistance – Intact Family	Full Medicaid Benefits	
087	Children up to Age 6	Full Medicaid Benefits	
088	Pregnant Women and children under Age 1, under 185% FPL	Full Medicaid Benefits, Except beneficiaries Age 21 and older	Eyeglasses & Dental for beneficiaries Age 21 and older
090	1973 Grandfathered Case	Full Medicaid Benefits	
091	Child Under Age 19, under 100%	Full Medicaid Benefits	
093	Cost of Living	Full Medicaid Benefits	
094	Disabled Adult Child-DAC	Full Medicaid Benefits	
095	Widow(er) 60+yrs	Full Medicaid Benefits	
096	Widow(er) 50+yrs	Full Medicaid Benefits	
099	Children Health Insurance Program (CHIP), under 200% FPL	No Medicaid Benefits, Administered by BC/ BS 1-877-870-3110	All
999	Converted record only-not enough information		
KK	K-Baby – Newborns, under 1yr old	Full Medicaid Benefits To 1 yr Birthday	No Benefits after 1yr Birthday

***If Medicare-eligible with full Medicaid benefits:** Pharmacy coverage is thru Medicare Part D. Medicaid only covers Medicare excluded drugs.

Medicaid Eligibility for Non-Qualified Immigrants - Emergency Medical Services Only

The Division of Medicaid must provide coverage to immigrants that are not otherwise eligible for Medicaid due to their immigration status. An immigrant who is undocumented or in the U.S. only on a temporary basis or one who cannot qualify under Medicaid's statutory categories of "qualified" aliens can be covered under the following circumstances:

A. **The immigrant must be otherwise eligible for Medicaid**, meaning the immigrant fits into a covered category of eligibility that is limited to:

- Children under age 19, or
- Pregnant women, or
- Low income adults (mother or father) with dependent children under age 18, or
- Disabled individuals (of any age), or
- Aged individuals (age 65 and over).

Immigrants that do not fit into any of the 5 broad categories described above **cannot** qualify for emergency medical services under Medicaid.

B. **An "emergency" medical condition must exist.** An emergency is defined as a medical condition, after sudden onset, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunctions of any bodily organ or part.

The above definition does not include care and services related to either an organ transplant procedure or routine prenatal or post-partum care. An emergency medical condition does include labor and delivery.

C. **The time limit for filing an application for coverage is the same as any Medicaid application**. The applicant must file for the service in a timely manner because Medicaid can only certify eligibility for up to 3 months prior to the application. For example: If the emergency service occurred in June, application for coverage of the service through Medicaid must be filed by the end of September for the June emergency to be covered.

Immigrants that can qualify for emergency medical services should be directed to **apply for coverage of the emergency condition**, which is usually limited to one day of service coverage, at the **Medicaid Regional Office that serves the county where the immigrant resides.**

Retroactive Eligibility

If an individual meets certain financial and need requirements before applying for Medicaid, eligibility for Medicaid is possible during all or part of a **three month period before the date of the application**. This period is called **retroactive eligibility**.

When a beneficiary has paid a provider for a service for which the beneficiary would be entitled to have payment made under Medicaid, the provider has the option to refund the payment to the beneficiary and bill Medicaid for the service if the beneficiary furnishes valid eligibility identification (a valid Medicaid identification card for the dates of services provided) during the timely filing requirements (discussed in Section 1.12).

Some services provided during the period of retroactive eligibility are special services that require prior authorization. The services cannot be denied because of failure to secure such prior authorization, but the authorization must be obtained before payment can be made.